

FEB 26 2007

DEPARTMENT OF HEALTH  
Center for Health Statistics

## CHARITY CARE POLICY

### POLICY:

The District is committed to the provision of health care services to all persons in need of medical attention regardless of ability to pay. In order to protect the integrity of operations and fulfill this commitment, the following criteria have been established to assist staff in making consistent objective decisions regarding eligibility for charity care. This policy voluntarily goes beyond the minimum requirements of WAC 246-253.

### COMMUNICATIONS TO THE PUBLIC:

The district's charity care policy shall be made publicly available through the following elements:

1. A notice advising patients that the hospital provides charity care shall be posted in key public areas of the hospital and clinic.
2. The hospital will distribute a written notice of the hospital's charity care policy to patients upon patient request.
3. Both the written information and the verbal explanation shall be available in any language spoken by more than ten percent of the population in the hospital's service area.
4. The hospital shall train front-line staff to answer charity care questions effectively or direct such inquiries to the appropriate department in a timely manner.
5. Written information about the hospital's Charity Care Policy shall be made available to any person who requests the information, either by mail, by telephone, or in person.

### ELIGIBILITY CRITERIA

Charity care is generally secondary to all other financial resources available to the patient, including group or individual medical plans, Worker's Compensation, Medicare, Medicaid or medical assistance programs, other state, federal, or military programs, third party liability situations (e.g., auto accidents or personal injuries), healthcare savings accounts or any other situation in which another person or entity may have a legal responsibility to pay for the costs of medical services.

Elective services, not considered medically necessary by the physician, may not be considered for charity care. Certain preventative clinic services will be considered on a case-by-case basis. Residential services (nursing home, swing bed and assisted living) are also not eligible for charity care.

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In those situations, where appropriate primary payment sources are not available, patients shall be considered for charity care under this policy based on the following criteria:

- The full amount of District charges will be determined to be charity care for a patient whose gross family income is at or below 100 percent of the current federal poverty level (consistent with WAC 246-435).
- Effective 12/15/2006, the full amount of District charges will be determined to be charity care for a patient whose gross family income is at or below 200 percent of the current federal poverty level.
  - This is beyond the requirements of WAC 246-435.
  - This replaces the sliding fee scale in place prior to 12/15/2006.
  - See note below for implementation and transition to this level of adjustment.

Implementation of 200 percent level: Patient balances remaining unpaid as of 12/15/06 related to sliding fee schedule obligations will be adjusted off as charity care. Refunds for amounts paid prior to implementation date (12/15/06) will not be issued.

**PROCESS OF ELIGIBILITY DETERMINATION**

A. Initial Determination:

- 1) The hospital shall use an application process for determining eligibility for charity care.
- 2) The initial determination of eligibility for charity care shall be completed at the time of admission or as soon as possible following initiation of services to the patient.
- 3) Pending final eligibility determination, the hospital will not initiate collection efforts or request deposits, provided that the responsible party is cooperative with the hospital's efforts to reach a final determination of sponsorship status and provides the requested documentation in a timely manner..
- 4) If the hospital becomes aware of factors which might qualify the patient for charity care under this policy, it shall advise the patient of this potential and make an initial determination that such account is to be treated as charity care.

B. Final Determination:

- 1) Prima Facie Write Offs. In the event that the responsible party's identification as an indigent person is obvious to hospital personnel, and the hospital can establish that the applicant's income is clearly within the range of eligibility, the hospital will grant charity care based solely on this initial determination. In these cases, the hospital is not required to complete full verification or documentation. (In accordance with WAC 246-453-030 (3)).

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- 2) Charity care forms, instructions, and written applications shall be furnished upon request, when need is indicated, or when financial screening indicates potential need. All applications, whether initiated by the patient or the hospital should be accompanied by documentation to verify information indicated on the application form. Any of the following documents shall be considered sufficient evidence upon which to base the final determination of charity care eligibility:
  - a. A "W-2" withholding statement.
  - b. Pay stubs from all employment during the relevant time period.
  - c. An income tax return from the most recently filed calendar year.
  - d. Forms approving or denying eligibility for Medicaid and/or state-funded medical assistance.
  - e. Forms approving or denying unemployment compensation.
  - f. Written statements from employers or DSHS employees.
- 3) During the initial request period, the patient and the hospital may pursue other sources of funding, including Medical Assistance and Medicare. The responsible party may be required to provide written verification of ineligibility for all other sources of funding. The hospital may not require that a patient applying for a determination of indigent status seek bank or other loan source funding.
- 4) Usually, the relevant time period for which documentation will be requested will be twelve months prior to the date of application. However, if such documentation does not accurately reflect the applicant's current financial situation, documentation will only be requested for the period of time after the patient's financial situation changed.
- 5) In the event that the responsible party is not able to provide any of the documentation described above, the hospital shall rely upon written and signed statements from the responsible party for making a final determination of eligibility for classification as an indigent person (WAC 246-453-030(4)).

C. When to Apply - The hospital will allow a patient to apply for charity care at any point from pre-admission to final payment of the bill, recognizing that a patient's ability to pay over an extended period may be substantially altered due to illness or financial hardship, resulting in a need for charity services. If the change in financial status is temporary, the hospital may choose to suspend payments temporarily rather than initiate charity care.

D. Time Frame - The time frame for final determination and appeals is as follows:

- 1) Each charity care applicant who has been initially determined eligible for charity care shall be provided with at least 14 calendar days, or such time as may reasonably be necessary, to secure and present documentation in

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support of his or her care application prior to receiving a final determination of sponsorship status.

- 2) The hospital shall notify the applicant of its final determination within 14 days of receipt of all application and documentation material.
- 3) The responsible party may appeal the determination of eligibility for charity care by providing additional verification of income or family size to the Administrator within thirty (3) days of receipt of notification.
- 4) The timing of reaching a final determination of charity care status shall have no bearing on the identification of charity care deductions from revenue as distinct from bad debts, in accordance with WAC 246-453-202(10).

E. Reimbursement – If the patient or responsible party has paid some or all of the bill for medical services and is later found to have been eligible for charity care at the time services were provided, he/she shall be reimbursed for any amounts in excess of what is determined to be owed. The patient will be reimbursed within 20 days of receiving the charity care designation.

- See note above regarding refunds during time of transition to 200 percent adjustment level.

F. Adequate Notice of Denial:

- 1) When an application for charity care is denied, the responsible party shall receive a written notice of denial, which include:
  - The reason or reasons for the denial
  - The date of the decision
  - Instructions for appeal or reconsideration.
- 2) When the applicant does not provide requested information and there is not enough information available for the hospital to determine eligibility, the denial notice also includes:
  - A description of the information that was requested and not provided, including the date the information was requested.
  - A statement that eligibility for charity care cannot be established based on information available to the hospital.
  - The eligibility will be determined if, within thirty days from the date of the denial notice, the applicant provides all specified information previously requested but not provided.
- 3) The Chief Financial Office (CFO) and/or Administrator will review all appeals. If this review affirms the previous denial of charity care, written

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notification will be sent to the responsible party and the Department of Health in accordance with state law.

- G. Remaining Eligible - A patient may continue to receive services and be eligible for charity care without completing a new charity care application. The hospital may re-evaluate the patient's eligibility for charity care at any time, but must re-evaluate at least annually. The hospital may require the responsible party to submit a new charity care application and documentation.

**DOCUMENTATION AND RECORDS:**

- A. Confidentiality - All information relating to the application will be kept confidential. Copies of documents that support the application will be kept with the application form.
- B. Retention - Documents pertaining to charity care shall be retained for five years.

Date: 1-12-07 Approved by: Mar B. Admin  
Annita Edwards

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Lincoln County Public Hospital District No. 1  
D.b.a. **ODESSA MEMORIAL HEALTHCARE CENTER**

**NOTICE OF AVAILABILITY OF  
UNCOMPENSATED CARE**

Lincoln County Public Hospital District No. 1 is committed to the provision of health care services to all persons in need of medical attention regardless of ability to pay. In order to protect the integrity of operations and fulfill this commitment, specific criteria have been established to assist staff in making consistent objective decisions regarding eligibility. Eligibility for uncompensated care is determined by measuring personal or family incomes against established Federal poverty levels.

If you think you may be eligible for uncompensated care, please inquire at the hospital or clinic business offices. You will receive more information and an application.

District Administration will make a written determination of your eligibility to pay within fourteen (14) days following receipt of your application. Verification of income must be submitted with the application. Verification is very important, as we must show in our records how we determined your income to receive credit for uncompensated services. If you qualify, your hospital and clinic services may be provided at no cost to you.

To be eligible for uncompensated care, your family income must be at or below the following levels:

SIZE OF FAMILY	YEARLY INCOME
1	19,600
2	26,400
3	33,200
4	40,000
5	46,800
6	53,600
7	60,400
8	67,200
Family units more than 8 persons, add \$3,260 for each additional person.	6,800

Source: DHHS Web Page, Federal Register 01/24/2006  
Rev. 12/15/2006

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To be eligible for uncompensated care, your family income must be at or below the following levels:

<b>SIZE OF FAMILY</b>	<b>YEARLY INCOME</b>
1	20,420
2	27,380
3	34,340
4	41,300
5	48,260
6	55,220
7	62,180
8	69,140
Family units more than 8 persons, add \$3,480 for each additional person.	6,960